SOUTH DAKOTA BOARD OF NURSING
SOUTH DAKOTA DEPARTMENT OF HEALTH
4305 S. LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS, SD 57106-3115
(605) 362-2760 ♦ FAX: 362-2768

CERTIFIED NURSE AIDE REGISTRY RENEWAL APPLICATION

To renew your certificate, provide verification that you have been employed as a nurse aide for a minimum of 8 hours during the past 2 years. Your employer/former employer will complete and sign the lower Section. Please return the completed form to the South Dakota Board of Nursing; a new certificate will be mailed to you.

THIS SECTION TO BE COMPLETED BY APPLICANT

NAME (FIRST/MIDDLE/LAST):

OTHER NAMES USED (MAIDEN, FORMER):

CERTIFICATE #A0

SS#

DATE OF BIRTH:

ADDRESS:

CITY: STATE: ZIP:

TELEPHONE:

EMAIL:

Have you ever been found guilty of abuse or neglect? ☐ YES ☐ NO

Have you ever been convicted of abusing another person? ☐ YES ☐ NO

If you answered YES to either question above, please explain dates and circumstances on a separate piece of paper.

I have been employed as a Certified Nurse Aide within the last twenty-four months. ☐YES ☐NO

APPLICANT SIGNATURE: _____ DATE: _____

EMPLOYMENT VERIFICATION – THIS SECTION TO BE COMPLETED BY EMPLOYER

Dates of employment: FROM _____
TO _____ (If presently employed, use "present")

Total number of hours worked during this period: _____

I declare and affirm that, according to our records and to the best of my knowledge and belief, all of the information provided on this Employment Verification is complete, true, and correct.

EMPLOYER:

ADDRESS:

TELEPHONE:

DATE:

_____
EMPLOYER REPRESENTATIVE SIGNATURE / TITLE

07/01/2009